

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011197
STATE FILE NUMBER

APR 6 1959 Registration District No. Primary Registration District No. Registrar's 2 3023

00
57

37
6

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN ST. LOUIS.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1. 6 DAYS		d. STREET ADDRESS (If outside, give location) 8524 DRURY LANE	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES F. W. MEYER		4. DATE OF DEATH Month Day Year MAR CH 24, 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 25 1885
9. AGE (In years last birthday) 73		10. FUNDING YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEAT CUTTER		10b. KIND OF BUSINESS OR INDUSTRY FOOD	
11. BIRTHPLACE (City and state or country) ST. LOUIS MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME GOTTLIEB MEYER		13b. MOTHER'S MAIDEN NAME BOKEL	
14. NAME OF HUSBAND OR WIFE LUELLA MEYER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO.	
16. SOCIAL SECURITY NO. 489-14-5907A		17. INFORMANT LUELLA MEYER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) New and old myocardial infarction DUE TO (b) Thrombosis of coronary artery DUE TO (c) Coronary arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Death occurred at 3/18/59 8:40 A.M. 3/24/59 and last saw her alive on 3/24/59		21b. ADDRESS 1515 LAFAYETTE AVE	
22a. SIGNATURE (Degree or title) J. Q. Chapman M.D.		22c. DATE SIGNED 3/24/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 3/27/59	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK	23d. LOCATION (City, town, or county) (State) ST. LOUIS, COUNTY MO.
24. FUNERAL DIRECTOR BUCHHOLZ	25. DATE RECD. BY LOCAL REG. MAR 25 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All deaths in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Harold W. Buckhous

Licensed Embalmer No. 4551

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.